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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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RESPONDENT'S BRIEF IN OPPOSITION

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QUESTION PRESENTED

The saving clause of Section 514(b)(2)(A) of ERISA operates "broadly to preserve the States' lawmaking power over" insurance by excepting from pre-emption any law of any State which regulates insurance. The question fairly presented by the Petition is:

Whether the Court should review a decision of the United States Court of Appeals for the Fourth Circuit holding that Virginia Code § 38.2-3407(B), which protects policyholders by regulating health insurers who restrict policy coverage by limiting the number or types of providers that policyholders may utilize and still get full reimbursement, is saved from ERISA pre-emption under the rationale of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

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Respondent's Brief In Opposition

Respondent Stuart Circle Hospital Corporation[1] ("Stuart Circle") respectfully requests that this Court deny the Petition for writ of certiorari of Aetna Life Insurance Company and Aetna Health Management (collectively, "Aetna"), which seeks review of the judgment and opinion of the United States Court of Appeals for the Fourth Circuit in this case.

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[1] In accordance with Rule 29.1, Respondent states that it is a subsidiary of Charter Medical Corporation.

OPINIONS AND ORDERS BELOW

The order, opinions, and judgments of the Fourth Circuit and the District Court are accurately identified and reproduced in the Appendix ("App.") to the Petition. Contrary to Aetna's statement, the opinion of the District Court is officially reported at 800 F. Supp. 328.

STATUTORY PROVISIONS INVOLVED

Aetna failed to reproduce in its Petition several provisions of Virginia Code § 38.2-3407 which are relevant to this case. The entire text of this section is reproduced in the Appendix hereto.

STATEMENT OF THE CASE

The Statement contained in the Petition filed by Aetna omits critical facts and obscures others; the Petition does not contain all "facts material to the consideration of the questions presented." Rule 14.1(g).

As part of its Insurance Code, Virginia has enacted a statute that protects consumers by regulating the terms of health insurance policies or contracts which take the form of preferred provider arrangements, commonly known as insurance PPOs. The statute is explicitly confined to insurers who sell a particular kind of insurance product. It regulates the offering of insurance policies "*that specify how services are to be covered* when rendered by preferred and nonpreferred classifications of providers." Virginia Code § 38.2-3407(A), (E) (emphasis added). If an insurer restricts the policy coverage by limiting the "numbers [or] types" of preferred providers that policyholders can utilize and still get full reimbursement, then the

statute comes into play.[2] It prohibits an insurer who issues such a policy from excluding any provider willing to meet the insurer's PPO terms, unless there is a reasonable basis for "discriminat[ing]" against them by withholding preferred provider status. *Id.*, § 38.2-3407(B).

Like other forms of commercial insurance products, the PPO approach has the potential for abuses that ultimately threaten consumer welfare.[3] A danger is that insurers anxious to cut costs will limit the number or types of preferred providers so severely as to interfere with the legitimate interests of policyholders and their families in having a reasonable and economical range of choice of hospitals and physicians. The Virginia legislature chose to safeguard these interests by enacting Code § 38.2-3407. The statute allows insurers to offer insurance policies with limited coverage but also assures policyholders of sufficient

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[2]Aetna wrongly implies that the Virginia statute regulates insurance companies which simply administer self-funded employee benefit plans, *i.e.*, plans that do not purchase insurance. (*See* Pet. at 4.) In fact, the only activity of insurers regulated by the statute is their performance of an insurance function. The Fourth Circuit removed any doubt that this is so, holding that "ERISA's deemer clause, 29 U.S.C. § 1144(b)(2)(B), precludes employer self-funded employee benefits plans from being brought within the scope of Va. Code § 38.2-3407." (App. 10a.) *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985).

[3]The record shows that Aetna's PPO is the third, and most recent, development in its "triple option" insurance portfolio. Subscribers are offered the option of receiving health care benefits from an indemnity policy, a health maintenance organization (HMO), or a PPO. A danger in indemnity insurance is over-utilization of health care services, and a corresponding danger of HMOs is under-utilization. State insurance regulation exists to balance the competing interests of insurers and consumers in these and other matters.

choice of providers who perform the terms of the insurance contract.[4]

An insured's choice of providers is an integral part of the coverage furnished by a health insurance policy. As the Fourth Circuit emphasized in its opinion, treatment and cost are vital components of the insurer-policyholder relationship that centers around the insurance contract. App. 10a. Because the insurance policy alone defines the limits of coverage, the insured's choice of a provider resides within the contractual relationship between the insurer and insured. The Virginia statute imposes requirements upon insurers with the intent of affecting this relationship. By prohibiting insurers from undue restriction of insurance coverage, the Virginia statute gives priority to an insured's freedom to choose doctors and hospitals. App. 12a. If a PPO unreasonably restricts a patient's choice of a suitable provider of treatment, even though the favored providers may meet the insurer's standards, the policyholder is forced to obtain care from an unwanted provider or to pay an additional charge for utilizing a provider of his or her choice. In either case, such a restriction necessarily affects the quality and cost of

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[4]Aetna mischaracterizes the Virginia statute when it asserts that the law "mandates that no health care provider willing to meet the terms and conditions of such a PPO may be excluded" from the network. (Pet. at 4). The statute permits even willing providers to be excluded if the insurer's terms and conditions for inclusion in the PPO network do not "discriminate unreasonably against or among such health care providers." Va. Code § 38.2-3407(B). *See HCA Health Services of Va., Inc. v. Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 207 (E.D. Va. 1990), *appeal dismissed*, 957 F.2d 120 (4th Cir. 1992).

the treatment benefits available to the policyholder under the insurance contract. App. 10a.[5]

Mindful of these matters, the Fourth Circuit conducted a *de novo* review of the District Court's grant of summary judgment in favor of Aetna, and unanimously reversed. Applying the two-step analysis that ERISA requires, the Fourth Circuit first considered whether the Virginia statute comes within the terms of ERISA's pre-emption clause. The court found that the Virginia statute applies to health benefit programs operated by insurers and "has at its core a provision relating to the *benefits* which an insured may receive from an insurer's PPO." App. 7a (emphasis added). The court concluded that Va. Code § 38.2-3407 "relates to" employee benefit plans, 29 U.S.C. § 1144(a), and was therefore pre-empted "unless ERISA's insurance savings clause applies." App. 7a.

In the part of its decision for which Aetna seeks review, the Fourth Circuit then considered whether the Virginia statute is saved from pre-emption by ERISA as a law "which regulates insurance."[6] In conducting

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[5]Aetna's suggestion (Pet. at 3, 5-6) that patients are indifferent to the matter of who provides them with their medical treatment benefits, or that policyholders' risks are unaffected by the arrangements their insurers make to perform the health insurance contract, is therefore unfounded and incorrect. *See* App. 9a-10a.

[6]29 U.S.C. § 1144(b)(2)(A). Although the pre-emption and insurance saving clauses of ERISA are to be analyzed separately, the Fourth Circuit's rationale for holding that the Virginia statute satisfies the pre-emption clause is both relevant to and logically consistent with its saving clause analysis. That is to say, if the statute relates to employee benefit plans by regulating the "benefits" available to insureds under insurance PPO contracts, as the Fourth Circuit held, then it follows that the statute regulates insurance and is saved from pre-emption, as the court also held. Aetna's Petition ignores the interplay of these two parts of the Fourth Circuit's decision.

that analysis, the Fourth Circuit viewed as controlling this Court's analysis and holding in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The court applied the tests announced in *Metropolitan Life* (App. 8a-10a) and reasoned that the Virginia statute is "conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance and consequently not pre-empted by ERISA." App. 10a. The Fourth Circuit expressly rejected Aetna's claim that the Virginia statute is analogous to the practice at issue in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Following the rationale of *Metropolitan Life* and several other courts,[7] the Fourth Circuit held that *Royal Drug* is "not precedent applicable to the Virginia statute pertaining to mandatory providers in insurers' PPOs." App. 12a-13a.

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[7] *See Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986); *Blue Cross Hospital Serv. of Mo., Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985) (in banc).

REASONS FOR DENYING THE WRIT

SUMMARY OF ARGUMENT

The Petition raises no issue that warrants review. No significant or unsettled question of federal law is presented, no conflict among the Circuits exists, and the decision of the Fourth Circuit is correct on the merits and is not contrary to ERISA or any of the several applicable decisions of this Court.

The Petition raises no important questions of federal law which have not already been settled by the Court. Rule 10.1(c). In *Metropolitan Life*, the Court announced the two-part test for determining the scope of ERISA's insurance saving clause, which the Fourth Circuit faithfully employed here and which petitioners would have this Court employ once again. The Court in *Metropolitan Life* held that state regulation regarding the substantive terms of insurance contracts, as here, falls "squarely within the saving clause" as laws which regulate insurance. Moreover, regardless of whether the Virginia statute is likened to the mandated-benefit law at issue in *Metropolitan Life*, as the Fourth Circuit held, or to a mandated-provider law, as Aetna suggests, *Metropolitan Life* also makes clear that both types of laws are subclasses of a matrix of state laws that regulate the content of insurance contracts, and hence the Virginia law is saved from ERISA preemption. All decisional authority of the federal and state courts on this point is to the same effect.

The Fourth Circuit has not "rendered a decision in conflict with the decision of another United States court of appeals on the same matter." Rule 10.1(a). Aetna in one breath suggests that the decision conflicts with the Third Circuit's antitrust decision in *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3rd Cir. 1993), and then in another concedes that no "direct"

conflict with *Ticor* actually exists, nor is there a split of circuit authority "on the precise issue in this case." This concession is not surprising. The outcomes in this case and in *Ticor* were different because the facts at issue in each case were materially different. In this case, unlike *Ticor*, the statute regulates the contents of an insurance contract and is therefore saved from pre-emption under the rationale of *Metropolitan Life*. Moreover, during the past Term, in *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202 (1993), this Court held that cases interpreting the scope of antitrust exemption contained in the "second clause" of section 2(b) of the McCarran-Ferguson Act, such as *Ticor*, do not control the issue in litigation here. *Ticor* itself recognizes the *Fabe* holding on this point.

Finally, the Fourth Circuit has not decided a federal question in a way that conflicts with applicable decisions of this Court. Rule 10.1(c). Sidestepping the Fourth Circuit's holding that *Metropolitan Life* controls the outcome of this case, Aetna argues that the decision below is contrary to this Court's earlier decision in *Royal Drug*, a non-ERISA case. The Fourth Circuit correctly pointed out, however, that unlike the drug reimbursement program at issue in *Royal Drug*, which affected *only* the relationship between insurers and providers, the Virginia statute affects the core relationship between insurers and insureds by regulating the coverage available to policyholders under the insurance contract. On this basis the Fourth Circuit refused to view *Royal Drug* as applicable precedent, consistent with *Metropolitan Life* and several other courts in parallel cases. Moreover, Aetna's argument fails to acknowledge that *Fabe* is explicit in holding that *Royal Drug* does not control cases, such as this one, where the issue concerns interpretation of the "first clause" of section 2(b) of the McCarran-Ferguson Act. The Fourth Circuit's decision, which reached the same result but for

different reasons, thus correctly applied and anticipated the applicable precedents of this Court.

At bottom, the Petition rests upon the novel argument that insurers such as Aetna, whose self-interested views about how best to promote the welfare of policyholders did not carry the day in the Virginia legislature, and who failed to convince the Fourth Circuit that ERISA nullifies this salutary form of state insurance regulation, ought now to have a hearing in this Court because this case presents important issues of public policy. But the Fourth Circuit's rejoinder is no less telling here than as before: "[The] legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision *is a concern of the legislature, not the judiciary*." App. 12a (emphasis added).

NO SPECIAL AND IMPORTANT REASONS EXIST FOR REVIEW ON WRIT OF CERTIORARI

A. The Fundamental Issues of Federal Law Raised by the Petition Have Already Been Settled by this Court

ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance...." This clause operates to except, or "save," state laws regulating insurance from pre-emption that would otherwise occur by application of the preceding provision of ERISA, 29 U.S.C. § 1144(a) (pre-empting state laws which "relate to" employee benefit plans). Aetna's Petition seeks review only of that portion of the Fourth Circuit's decision in which it held that the Virginia statute falls within the insurance saving clause.

This Court is no stranger to "the burgeoning volume of litigation involving ERISA preemption claims" in general,[8] and the insurance saving clause of ERISA in particular. It has comprehensively addressed the basic issues presented by Aetna's Petition in prior cases, and the principles declared by the Court in those cases squarely dictate the outcome of this case. The Court's precedents establish that ERISA's insurance saving clause broadly preserves the States' lawmaking power over insurance, even if the effect of such laws is *indirectly* to regulate employee benefit plans which purchase insurance; they articulate the legal standards for deciding whether a state law regulates insurance; and they hold that mandated-benefit and other similar laws which regulate the substantive content of insurance contracts are saved from ERISA pre-emption. Together, those precedents furnish all the guidance needed by the Fourth Circuit to decide this case correctly.

First of all, the basic principles for interpreting the scope of ERISA's insurance saving clause are firmly settled. The Court has established that the saving clause operates "broadly to preserve the States' lawmaking power over" insurance from ERISA pre-emption. *Metropolitan Life*, 471 U.S. at 740; *see id.* at 746 n.24 ("the saving clause is broad on its face and specific in its reference."). Moreover, the Court has instructed the courts to "presume that Congress did not intend to pre-empt areas of traditional state regulation" such as insurance. *Id.* at 740. These principles apply even if the effect of a state insurance law is indirectly to regulate employee benefit plans

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[8] *District of Columbia v. Greater Washington Bd. of Trade*, 113 S. Ct. 580, 586 & nn. 2-3 (1992) (Stevens, J. dissenting) (citing the Court's prior cases and noting that "[a] recent LEXIS search indicates that there are now over 2,800 judicial opinions addressing ERISA pre-emption.").

which purchase insurance. *Id.* at 747 (recognizing "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not."); *see FMC Corp. v. Holliday*, 498 U.S. 52, 64 (1990) ("the saving clause retains the independent effect of protecting state insurance regulation of insurance contracts purchased by employee benefit plans."). The insurance saving clause, therefore, is to be read broadly in exactly the opposite direction of the pre-emption clause—to preserve state regulation of insurance purchased by employee benefit plans from federal pre-emption.[9]

Second, this Court has settled the legal standards governing whether a state law "regulates insurance" within the meaning of ERISA's insurance saving clause. In *Metropolitan Life*, the Court addressed the saving clause in the context of determining whether a state statute which mandated a minimum level of mental health benefits regulated insurance and was

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[9]Consequently, Aetna's extensive argumentation (Pet. at 8-15) that the Fourth Circuit's decision will have "profound adverse consequences" for employee benefit plans which purchase insurance, does not address the question presented by its Petition. If ERISA's insurance saving clause removes a law such as the Virginia statute from pre-emption, then it is irrelevant that the law regulates, for better or worse, insurers who issue insurance contracts purchased by employee benefit plans. In such a case, the wisdom of the regulation is exclusively the concern of the States. Indeed, the Court in *Metropolitan Life* explicitly rejected the line of argument with which Aetna leads off its Petition:

> We also are aware that appellants' construction of [ERISA] would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress. (471 U.S. at 747.)

thus saved from ERISA pre-emption. The Court approached its task by employing a two-part analysis. First, the Court took a "common-sense" approach, finding that the statute at issue regulated insurance contracts and thus logically should be encompassed by the "which regulates insurance" language of the saving clause. 471 U.S. at 740-41. Second, the Court examined the case law which interpreted the phrase "business of insurance" with respect to the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*. To illustrate that Massachusetts' mandated-benefit law was a regulation of the business of insurance and, therefore, not pre-empted by ERISA, the Court reiterated:

> Congress was concerned [in the McCarran-Ferguson Act] with the type of state regulation that centers around the contract of insurance.... The relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement—these were the core of the "business of insurance." [T]he focus [of the statutory term] was on the relationship between the insurance company and the policyholder. *Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the "business of insurance."*

Metropolitan Life, 471 U.S. at 743-44 (*quoting SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)) (emphasis added). *See also United States Dep't of Treasury v. Fabe*, 113 S. Ct. at 2210 ("The broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention or aim' of adjusting, managing, or controlling the business of insurance.").

Finally, the Court in *Metropolitan Life* held that state mandated-benefit laws are "only one variety of a

matrix of state laws that regulate the substantive content of health-insurance policies to further state health policy." 471 U.S. at 729. The Court described other varieties of laws that fall within the matrix, and specifically identified mandated-provider laws as one of them.[10] It is no surprise, therefore, that after *Metropolitan Life* all of the courts presented with the question of whether a mandated health provider statute "regulates insurance" within the meaning of ERISA have agreed that it does. *See Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d at 1334-36; *Blue Cross Hospital Serv., Inc. v. Frappier*, 698 S.W.2d at 327 ("We see no viable distinction between the mandated-benefit provisions involved in *Metropolitan Life* and our mandated provider statutes.").[11]

The bottom line is that the Petition presents no important issue of federal law that has not already been settled by this Court's existing precedents.

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[10] *See id.* ("Others require insurers to offer or mandate that insurance policies include coverage for services rendered by a particular *type* of health-care provider.") (footnote omitted, emphasis added). *Compare* Va. Code § 38.2-3407(A) (authorizing health insurers to "offer preferred provider policies or contracts that limit the numbers and *types* of providers of health care services....") (emphasis added).

[11] Likewise, the Virginia Supreme Court viewed *Metropolitan Life* as controlling authority when it held that Va. Code § 38.2-4209, which regulates non-stock insurers in exactly the same way as the Virginia statute at issue here, regulates insurance within the meaning of ERISA's insurance saving clause. *Blue Cross and Blue Shield of Va. v. St. Mary's Hospital of Richmond*, 245 Va. 24, 33, 426 S.E.2d 117, 122 (1993).

B. The Fourth Circuit's Decision is in Harmony with the Applicable Decisions of this Court

The Fourth Circuit took care to conform its decision in this case to the decisions of the Court. The court first applied the *Metropolitan Life* test of "common sense" to the Virginia statute, which confirms the obvious proposition that the statute regulates the contractual relationship between the insurer and the insured and the type of policy which could be issued. App. 9a; *see Bell*, 798 F.2d at 1335 ("The selection of a particular provider is as integral to the bargained-for coverage as the coverage itself.").

Next, the Fourth Circuit considered whether the Virginia statute satisfies the *Pireno* criteria for finding the "business of insurance" under the McCarran-Ferguson Act. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982). The Fourth Circuit found that statute has the effect of "'transferring or spreading the policyholder's risk'" because it affects both "the type and cost of treatment available to an insured." App. 9a-10a. The statute regulates the benefits available to a policyholder under the insurance contract by making it less likely that he or she will be forced to accept care from an unsuitable provider or pay an extra-premium penalty for choosing another provider. Either way, the statute "spreads the cost component of the policyholder's risk among all the insureds" who pay premiums. App. 10a. Aetna's argument that the statute affects only an insurer's costs, and not also the quality and price of an insured's benefits, is thus plainly incorrect, as the Fourth Circuit and other courts have ruled. *See Bell*, 798 F.2d at 1335 (state laws that protect "the insured's right to choose the type of practitioner to fulfill the agreed upon coverage must figure into, and

play a part in, 'spreading and underwriting of a policyholder's risk.'").[12]

In reaching its decision, the Fourth Circuit correctly reasoned that the Virginia statute, which "has at its core a provision relating to the *benefits* which an insured may receive from an insurer's PPO," is conceptually similar to the mandated-benefit law that *Metropolitan Life* held was saved from ERISA pre-emption. App. 7a (emphasis added), 10a. Aetna argues, as it did below, that "[t]his case involves a mandatory *provider* law fundamentally different from the mandatory benefit law at issue in *Metropolitan Life* . . . ." Pet. at 21 (emphasis in original). As the Fourth Circuit recognized, however, *Metropolitan Life* could not have been more clear in equating both types of laws as subclasses of an overall matrix of traditional state regulation of the content of insurance contracts that is saved from ERISA pre-emption. App. 10a; *see* 471 U.S. at 727-28. Aetna conveniently ignores the importance of this guidance in its Petition.

At the heart of Aetna's Petition is the claim that the Fourth Circuit's decision is contrary to this Court's decision in *Royal Drug*. This is wrong in two independent respects. First, Aetna overlooks crucial fact differences between *Royal Drug* and this case, which the Fourth Circuit correctly understood as

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[12]The Fourth Circuit also correctly decided that the Virginia statute satisfies the second and third of the *Pireno* criteria. The court found that insurers' practice of restricting the coverage of insurance contracts by limiting the number and types of providers who deliver health care benefits to insureds affects basic components of health insurance, treatment and cost. As such, Virginia's regulation of those components is "an integral part of the policy relationship between the insurer and the insured" and is limited to the "insurance industry." App. 10a. Aetna abandons any direct challenge to the Fourth Circuit's holding on these points.

depriving *Royal Drug* of any precedential value here.[13] Second, Aetna fails to appreciate that this Court's recent decision in *Fabe* holds that *Royal Drug* does not control cases, such as this one, where the issue is whether a state law "regulates the business of insurance."

The Fourth Circuit found that the Virginia statute is a benefit-regulation law similar to the statute in *Metropolitan Life* because it "has at its core a provision relating to the benefits which an insured may receive from an insurer's PPO." App. 7a. An insured's "treatment and costs are important components of health insurance"; these benefits are "integral parts of the relationship between insurer and insured." *Id.* at 10a. The Virginia statute, which regulates the practice of insurers of restricting these benefits, thus affects the heart of the relationship between insurers and insureds, not simply or only the relationship between insurers and providers. *Id.* at 12a. In contrast, "[t]he practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits" to policyholders. *Id.*; *see Royal Drug*, 440 U.S. at

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[13]Aetna also attempts to suggest that there is a conflict within the Fourth Circuit with respect to the meaning of *Royal Drug*. (Pet. at 24-26.) However, Rule 10.1(a) makes no reference to a conflict within a circuit; it speaks only to a conflict with another circuit. In any event, there is no conflict within the Fourth Circuit. The Circuit's 1980 antitrust decision cited by Aetna, *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), is inapposite to the facts of this case and relied principally upon *Royal Drug*. Having correctly decided that *Royal Drug* has no precedential value in this case, the Fourth Circuit can hardly be faulted for disregarding Aetna's "copious citation" of *Virginia Academy*.

213-14.[14] Just as the Court in *Metropolitan Life* did not consider *Royal Drug* to be precedent applicable to a statute prescribing mandated-benefits in health insurance contracts, the Fourth Circuit correctly rejected Aetna's suggestion that *Royal Drug* is applicable to this case. *See* App. 12a-13a; *Bell*, 798 F.2d at 1335 ("Unlike *Royal Drug*, . . . the provider practice at issue in this case involves the very implementation of the terms of the policy."); *Frappier*, 698 S.W.2d at 327 (on remand for consideration in light of *Metropolitan Life*) (declining to follow *Royal Drug* because the state statutes at issue "clearly relate to the benefits available to insured persons under health insurance contracts.").

In addition, although it was unnecessary to its decision, the Fourth Circuit's refusal to follow *Royal Drug* nonetheless correctly anticipated this Court's

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[14]The issue in *Royal Drug* was whether the federal antitrust laws could be invoked by a group of drug stores who complained that an insurer had violated the Sherman Act by entering into agreements fixing a maximum price at which the insurer would reimburse stores who filled prescriptions for its policyholders for $2 apiece. *Id.* at 207-08. The Court's analysis in that case was driven by crucial facts that distinguish *Royal Drug* from this case, which Aetna overlooks in its Petition. In *Royal Drug* the Court emphasized that policyholders were "basically unconcerned" with the insurer's reimbursement arrangement with drug stores because it "merely" reduced the insurer's costs without also affecting policyholder-insurer relationship to any significant degree. *Id.* at 214 & n.11. That is, prescriptions would always be available to policyholders for $2 regardless of the details of reimbursement between the insurer and drug store. The benefit structure of the insurance policy and, therefore, the policyholder's risk, were not materially affected by the reimbursement arrangement. In marked contrast, the Fourth Circuit here found that insurers' practice of restricting policy coverage by limiting the number and types of eligible medical providers directly implicates "important" components of policyholder risk, treatment and cost, which are "integral parts of the relationship between insurer and insured." App. 10a.

decision in *Fabe*. ERISA's insurance saving clause excepts from pre-emption any state law which "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). *Fabe* has clarified that whether a state law regulates insurance under this section of ERISA is to be determined by the same criteria used to determine whether a state law is saved from federal pre-emption by the *first* clause of section 2(b) of the McCarran-Ferguson Act. *See* 15 U.S.C. § 1012(b) ("No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance, ..."). In *Fabe*, this Court held that *Royal Drug* and other cases (such as *Ticor*) which interpret the scope of the antitrust exemption of the *second* clause of section 2(b) of the Act—where the word "regulate" does not appear—do not control interpretation of the statutory language at issue in *Fabe*, and thus in this case as well. The Court in *Fabe* reasoned that:

> Both *Royal Drug* and *Pireno*, moreover, involved the scope of the antitrust immunity located in the *second* clause of § 2(b). We deal here with the *first* clause, which is not so narrowly circumscribed. The language of § 2(b) is unambiguous: the first clause commits laws "enacted . . . for the purpose of regulating the business of insurance" to the States, while the second clause exempts only "the business of insurance" itself from the antitrust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself, as petitioner urges us to do, would be to read words out of the statute. This we refuse to do.

113 S. Ct. at 2209-10 (emphasis in original). On this basis the *Fabe* Court refused to follow *Royal Drug*.[15]

Fabe thus adds gloss to *Metropolitan Life*, where the Court first explained why cases interpreting the scope of the McCarran-Ferguson Act are relevant to interpretation of ERISA's saving clause: "The ERISA saving clause, with its *similarly worded* protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life*, 471 U.S. at 744 n.21 (emphasis added). ERISA's insurance saving clause and the first clause of section 2(b) of McCarran-Ferguson contain the same language and both serve the same policy. Because, as *Fabe* recognized, the second clause of section 2(b) is worded differently and serves a different purpose, 113 S. Ct. at 2210, *Royal Drug* does not control this case. The Fourth Circuit's decision, therefore, cannot be in conflict with *Royal Drug*.

C. The Wisdom of the Public Policy Choice Made by the Virginia Statute is a Concern of the Legislature, not the Judiciary

In the final analysis, the Petition is far more a reflection of Aetna's disagreement over the wisdom of legislative policy inherent in the Virginia statute than a genuine claim that the Fourth Circuit's decision warrants exercise of supervisory intervention by this

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[15]The dissenting opinion in *Fabe* acknowledges the majority's holding that "cases such as *Royal Drug*... do not control cases in which the first clause of [section 2(b) of McCarran-Ferguson] is at issue." 113 S. Ct. at 2215 (Kennedy, J., dissenting). The Third Circuit in *Ticor* acknowledged the same point. 998 F.2d at 1136. The holding in *Fabe* thus defeats Aetna's suggestion of an inter-circuit conflict here.

Court. Argumentation is hardly needed, however, to demonstrate that the judiciary has no authority to abrogate a function reserved by Congress to state regulators. Mindful of this basic truth, the Fourth Circuit appropriately declined Aetna's invitation to second-guess the judgment of the Virginia General Assembly about how best to protect the welfare of its citizens:

> Aetna's claim that its PPO is simply a commercial transaction that reduces the cost of insurance overlooks the decision of the Virginia General Assembly to give priority to an insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums. This legislative decision to favor an insured's choice of providers does not compel preemption. The wisdom of this decision is a concern of the legislature, not the judiciary. (App. 12a.)

If, as Aetna speculates (Pet. at 26), a direct split of authority among the circuits may never arise on the precise issue presented in this case, it will be because future courts are as prudent as the Fourth Circuit was in respecting the limits of judicial power. No sound reason exists why this Court would or should conclude any differently.[16]

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[16]Even if this Court were a proper forum for resolving public policy choices, which it obviously is not, there is further reason for the Court to decline to issue the writ. The Administration has asked Congress to decide whether to enact legislation expressly pre-empting States' "willing provider" laws in certain circumstances. *See Preliminary Draft of the President's Health Reform Proposal 76* (1993). Regardless of how Congress decides this complex matter, the issue of the legal status of state laws such as the Virginia statute may well be settled conclusively without further expenditure of judicial resources.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX

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STATUTORY PROVISIONS

Virginia Code § 38.2-3407

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. For the purposes of this section, "preferred provider policies or contracts" are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.